Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RONALD G CORLEY, MD
10109 MCKALLA PLACE, STE E
AUSTIN, TX 78758

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-3100-01

MFDR Date Received
JUNE 12, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was still reduced in error. This claim was for a Division ordered Designated Doctor Exam. We billed a total of $1,750.00 for this claim but were only $500.00. The explanation given on the EOB justifying the denial states: *THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED,* however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No carrier response received

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2012	CPT Code 99456-W5-WP	$150.00	$ 150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 13, 2012
   - 1 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- 1 – This procedure is included in another procedure performed on this date.

Explanation of benefits dated March 31, 2012

- 1 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 1 – This procedure is included in another procedure performed on this date.

Issues

1. Is the disputed service billed appropriately?
2. Was the Designated Doctor (DD) examination reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT Code 99456 W5-WP for $950.00 with one unit for a Division ordered Designated Doctor examination for Maximum Medial Improvement/Impairment.
2. Review of the submitted documentation supports that a Designated Doctor was requested to determine Maximum Medical Improvement and Impairment Rating per 28 Texas Administrative Code §134.204 (j)(3)(C), the reimbursement shall be $350.00. Supporting documentation shows Maximum Medical Improvement was reached with an Impairment Rating to one body area using the American Medical Association Guides to Evaluation of Permanent Impairment, Fourth Edition to the left hand, index finger and middle finger. Reimbursement for an Impairment Rating per 28 Texas Administrative Code §134.204 (j)(4)(C)(i)(ii)(1) is $150.00. The total Maximum Allowable Reimbursement (MAR) for the disputed CPT Code 99456 W5-WP is $500.00.
3. The respondent has previously reimbursed the requestor the amount of $0.00 for the disputed CPT 99456 W5-WP. Based upon the documentation submitted and the *Table of Disputed Services*, additional reimbursement in the amount of $150.00 is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order

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Authorized Signature

		June 21, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or

personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.